THE STATE OF NEW HAMPSHIRE

OFFICE OF THE ATTORNEY GENERAL

CHILD ABUSE AND NEGLECT:

A MANUAL FOR THE PEDIATRIC HEALTH CARE PROFESSIONAL

A Publication of the Attorney General's Task Force on Child Abuse and Neglect

Second Edition, 1999

Funding for this project and for the activities of the Attorney General's Task Force on Child Abuse and Neglect comes from the U.S. Department of Health and Human Services Administration on Children, Youth and Families through the Children's Justice Act Grant (#G-98-1NHCJA1) which is administered by the New Hampshire Department of Justice. Points of view in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Health and Human Services.

PREFACE

Child maltreatment, unfortunately, is an all-too common problem. In 1995, reports from state child protective services indicated that over a million American children had been victimized by abuse or neglect, a 27% increase over the numbers for 1990. Over 1,100 of these children died as a result of the maltreatment they suffered. Because of the scope of this problem, any practitioner who cares for children will be faced with situations involving abuse or neglect. Such cases can leave even the most experienced clinician distressed and thereby less objective and thorough. For this reason, an organized approach to diagnosis, evaluation and treatment is essential.

The health care professional has the following responsibilities when treating a minor who has, or may have been, abused or neglected:

1. **Prevention:** recognizing and intervening in high risk situations; providing anticipatory guidance to all parents and children
2. **Identification of abused/neglected children** based on their behavior or physical findings
3. **Examination of reportedly abused/neglect children** for documentation of any abnormal findings and collection of forensic evidence
4. **Identification of additional problems** resulting from abuse/neglect, e.g. sexually transmitted infections in a sexually abused child
5. **Diagnosing** possible, probable, or definite abuse/neglect
6. **Treating** (or referring) children with physical and emotional problems
7. **Reporting** to state agencies
8. **Providing support** for victims and their families
9. **Providing medical consultation** to social service agencies and the courts.

The successful handling of cases involving child abuse and neglect can only occur when the many people and agencies who deal with children are willing to work together and keep the welfare of those children their first priority. This cannot happen when somebody is looking to be the “hero” or the “boss.” No single person’s (or agency’s) role is superior to any others. For health care professionals, this means that when we counsel, interview, examine, diagnose, treat, report, and bear witness, we should always be attentive to the need for collaboration with our professional partners who also serve maltreated children.

HISTORY OF THE CHILD ABUSE AND NEGLECT PROTOCOL PROJECT

The Attorney General's Task Force on Child Abuse and Neglect is comprised of professionals from throughout the state, representing the many disciplines involved in the field of child maltreatment. The Task Force was established in 1989 with statewide representation from the medical, legal, law enforcement, victim advocacy, forensic science, and child protection communities. The Task Force was created to focus specifically on the problem of child abuse and neglect in New Hampshire. The first three years were spent evaluating the systems response to child maltreatment and developing guidelines to assist professionals. Tireless efforts, on the part of many, produced a 600 page, precedent setting publication entitled: **Child Abuse and Neglect: Protocols for the Identification, Reporting, Investigation, Prosecution and Treatment**. In April of 1993, a two-day statewide training conference was presented to a multidisciplinary audience to introduce the Protocols.

In addition to the Protocols, the Task Force continues to sponsor annual conferences and extensive multidisciplinary and discipline-specific training programs for professionals statewide. Other projects funded by the Task Force include support for the New Hampshire Child Fatality Review Committee; court publications for children and teens; interviewing room set-up; and the Sexual Assault Nurse Examiner (SANE) Child Abuse Training.

In 1997, a Medical Protocol Revision Committee was convened to revise the medical section of the Child Abuse Protocol. Under the direction and leadership of Wendy Gladstone, M.D., the Committee has updated and produced this comprehensive manual designed to assist pediatric health care professionals in the evaluation, diagnosis and treatment of children who may have been abused or neglected.

The Committee encourages duplication and distribution of this Protocol to broaden efforts to improve the medical community's response to child maltreatment.

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Pediatric health care professionals (HCP) are in an ideal position to prevent and detect child abuse and neglect. The attentive HCP may be the first professional to recognize warning signs of a potentially abusive family situation. A prompt intervention, whether through education or referral, may be invaluable to the safety and well-being of a child. For example, a parent education program can give parents with limited understanding of the behavior of their developmentally delayed child extra advice and support on how to cope when toilet training begins.

FAMILY STRESSES RAISING THE RISK OF ABUSE/NEGLECT

CHILD-PRODUCED STRESSES	SOCIAL/SITUATIONAL STRESSES
1. Physically different (e.g., handicapped)	1. Structural factors: poverty, unemployment, mobility, isolation, poor housing
2. Mentally different (e.g., delayed)	2. Parental relationship: discord-assault, dominant-submissive patterns
3. Temperamentally different (e.g., difficult)	3. Parent-child relationship: attachment problems, perinatal stress, punitive childrearing style, scape-goating, role-reversal, excess or unwanted children, foster care
4. Behaviorally different (e.g., hyperactive)	

PARENT-PRODUCED STRESSES	TRIGGERING SITUATIONS
1. Low self-esteem	1. Discipline (especially in toilet training)
2. Abused as a child	2. Argument, family conflict
3. Depression	3. Substance abuse
4. Substance Abuse	4. Acute environmental problem (e.g., loss of support)
5. Character disorder or psychiatric illness	
6. Ignorance of childrearing, misinterpretation of child's actions due to limited understanding of normal child development, unrealistic expectations	

(adapted from Bittner and Newberger, 1981)

DEVELOPMENTAL ISSUES ACROSS CHILDHOOD

Below are examples of how the above issues might surface during routine health supervision visits at different stages of a child's development. Also given are suggested examples of anticipatory guidance for parents and children.

A. INFANCY

1. Issues
   - An infant's crying can be very stressful.
   - Postpartum depression may appear.
   - Oppositional behavior is normal in the second year.
   - Skills are needed to handle typical aggressive behavior (biting, hitting) and temper tantrums.
   - Toilet training will likely challenge even the most capable parent.
2. Anticipatory guidance
   - Normal development.
   - Accept offers of help from family and friends to avoid feeling overwhelmed.
   - Positive discipline techniques are far better alternatives than spanking.
3. Example: "Sometimes babies cry no matter what you do, and it can make you feel like you're at the end of your rope. Has that ever happened to you? What helps you to keep from 'losing it'? Have you ever felt like you might get so mad you could hurt your child? Have you ever actually hurt your child?"

B. PRESCHOOL YEARS

1. Issues
   - Lying/stealing are typical at this stage.
   - Children are naturally curious about sex.
   - The child spends an increasing amount of time away from direct parent supervision.
2. Anticipatory guidance
   - Discipline by "time out", not spanking.
   - Teach children correct names for body parts and introduce the concept of privacy.
   - Know how to select safe child care and talk to children about their experiences with caretakers.
   - Teach children to say "no" and tell a trusted adult if touched in a way they feel is wrong (the "good touch/bad touch" rule) or on any part of the body usually covered by a bathing suit (the "bathing suit rule").
   - Teach children to keep away from strangers and not go off with a stranger.

3. Example for parents: "Does your child know not to get into a stranger's car, even if offered a gift, like money or a puppy?"
4. Example for children: "Sometimes people touch children in ways they do not like, like on a private part of the body (where a bathing suit usually goes). Has that ever happened to you? What would you do if somebody tried to touch you that way, even if it was somebody you know? Whom would you tell?"

C. SCHOOL AGE CHILDREN

1. Issues
   - Children spent increasing amounts of time out in the larger community.
   - Some children are learning to stay home alone for periods of time.
   - Peer pressure becomes an important force in a child's life.
   - Discipline by restriction of privileges is a much better technique than spanking.
2. Anticipatory guidance
   - Teach children to avoid isolated play areas.
   - Know who your child's friends and their families are.
   - Teach your child how to be safe when home alone.
   - Discuss differences between boys and girls, explain sexual behaviors and when they are appropriate, discuss how to say "no" to sexual advances.
   - Discuss how to handle peer pressure, anger and conflict resolution.
   - Have a family "secret password." Example for parents: "It's helpful to have a 'secret password' for your family to use in case you ever have to send someone unknown to get your child. When your child hears that person use the password, they know it's okay to go with them."
   - Example for children: "Why is it not a good idea to play somewhere far from other people, like in a playground where there are no other children around?"

D. ADOLESCENTS **(see Special Considerations page 14)**

1. Issues
   - Episodes of estrangement from the family are normal.
   - Adolescents learn to handle intimate relationships.
   - Adolescents will experiment with risky behaviors that could endanger their safety.
2. Anticipatory guidance
   - Discipline is best achieved by restriction of privileges, not spanking.
   - Hitchhiking is dangerous.
   - Some dating situations are potentially dangerous, such as going out with someone you don't know well to an isolated area or getting drunk or high (or being with someone who is).

- Nobody owes a date sexual favors in return for having had money spent on them.
- "No" means no.

3. Example for adolescents: "Sometimes young people your age have sexual experiences when they do not really want to or when they are forced to. Has that ever happened to you?"

SIGNS AND SYMPTOMS OF CHILD ABUSE AND NEGLECT

A. GENERAL BEHAVIORAL SIGNS AND SYMPTOMS

- Afraid of adults/parents or cowers when approached.
- Extremes of behavior: aggressive, withdrawn.
- Habit disorders: excessive nail biting, rocking.
- Avoids going home, arrives early at school, leaves late.
- Developmental regression.
- Poor peer relationships.
- Self-destructive behavior or comments.
- Depression, anxiety, suicide attempts.
- Substance abuse.
- School problems, truancy.
- Running away.
- Child reports maltreatment.

B. PHYSICAL ABUSE

1. Physical signs and symptoms
   - Unexplained or inadequately explained injuries.
   - Multiple injuries, especially in various stages of healing (be aware that simultaneously caused injuries may result in bruises of different colors and appearances since deep tissue bleeding may take several days to appear at the skin surface, while superficial bleeding may be visible immediately. Bruises may take on a variety of colors as they age and those that contain yellow areas are at least 18 hours old; further estimates about a bruise's age based solely on color have been challenged in the literature. See Schwartz and Ricci, 1996.
   - Injuries suggesting they were caused by a specific object (belt, hand, lighted cigarette).
   - Burns suggesting immersion (stocking or glove distribution on extremities or burns on back of legs and buttocks).
   - Marks suggesting restraints on ankles or wrists.

- Unexplained or complex fracture of the skull (especially in an infant), unexplained fractures of rib, long bone or face.
- Intracranial bleeding (subdural or massive subgaleal hematoma).
- Intraocular bleeding (retinal hemorrhage).
- Injuries not consistent with the child's developmental age (e.g., fractures or bruises in a pre-walking infant).
- Bruises in uncommon places (ears, cheeks, neck, abdomen, buttocks, perineum) or multiple sites. See Chadwick, 1992.
- Fractured, displaced or avulsed teeth.
- Injuries to the tongue, buccal mucosa, hard and soft palate, gingival alveolar mucosa or frenum.
- Bruises, lichenification or scarring at the mouth corners (from gags).
- Bite marks (bruising in an ellipcial or ovoid pattern) with an intercanine distance >2.5 cm may be caused by an adult and can be sometimes matched with the individual responsible for causing it. See American Academy of Pediatrics Committee on Child Abuse and Neglect and American Academy of Pediatric Dentistry, 1999.

2. Behavior signs and symptoms: see above under "A: General…" plus
   - Unusually apprehensive when other children cry.
   - Child reports that parents caused injury.
3. Other
   - Parents extremely protective or refuse social contact for the child.
   - Multiple visits for acute injuries, particularly at multiple sites (hospital emergency departments).
   - Unusual parent or child behavior, unusual parent/child interaction.

C. PHYSICAL NEGLECT

1. Physical signs and symptoms
   - Failure to thrive.
   - Poor hygiene.
   - Inadequate clothing for weather.
   - Severe sunburn, particularly in an infant.
   - Constant fatigue.
   - Unattended medical problems or injuries or dental conditions. A good resource for the latter is found at: moudeL@mail.health.state.mo.us or by calling 1-573-751-6247
   - Decayed or painful teeth.
2. Behavioral signs and symptoms: see above under "A. General…" plus
   - Begging or stealing food.

- Child states there is nobody home or no caretaker.
- Child is observed with level of supervision inadequate for developmental stage.

3. Emotional abuse and neglect: see above under "A. General…" plus
   - Rumination (self-induced vomiting in infants).
   - "Radar" stare.
   - Lack of affect with others.
   - Lack of eye contact.
   - Developmental lags.
   - Failure to thrive.
   - Overly compliant behavior.
4. Other
   - Parent unconcerned with child's behavior.
   - Parent repeatedly confines, frightens or ridicules child.
   - Parent permits child to engage in substance abuse or criminal activity over time.
   - Parent is repetitively inattentive in a way that harms the child.
   - Parent denies psychological care.

D. SEXUAL ABUSE

1. Definite evidence of abuse or sexual contact.
   a. Clear evidence of blunt force or penetrating trauma with no history of accident:
      1. Laceration of the hymen, acute.
      2. Bruising of the hymen.
      3. Perianal lacerations extending deep to the external and sphincter.
      4. Healed hymenal transection: an area where the hymen has been torn through, to the base, so there is no hymenal tissue remaining between the vaginal wall and the fossa or vestibular wall.
      5. Absence of hymenal tissue: wide areas in the posterior (inferior) half of the hymenal rim with an absence of hymenal tissue, extending to the base of the hymen, which is confirmed in the knee-chest position.
   b. Sperm or seminal fluid in or on a child's body.
   c. Pregnancy from nonconsensual intercourse.
   d. Positive, confirmed culture for Neisseria gonorrhea from genital, anal or pharyngeal source (non congenital).
   e. Evidence of syphyllis acquired after delivery.
   f. Witnessed abuse or cases where photographs or videotapes show child being abused.
   g. Confession by the alleged perpetrator to the acts described by the child.

h. HIV infection with no documented means of transmission other than nonconsensual sexual contact.

2. Probable Abuse
   a. Child gives a clear, consistent, and detailed description of being molested, with or without physical feelings.
   b. Physical findings suggestive of abuse/penetration: (findings that can only reasonably be explained by postulating that abuse or penetrating injury has occurred) with or without a history of abuse and with no history of accidental penetrating injury.
      1. Scar or fresh laceration of the posterior fourchette, not involving the hymen.
      2. Perianal scar.
   c. Positive culture (not rapid antigen test) for Chlamydia trachomatis from genital area in a prepubertal child over 2 years of age.
   d. Positive culture for herpes simple type II, from genital lesions.
   e. Trichomonas infection, diagnosed by wet mount or culture.
3. Possible Abuse
   a. Normal or nonspecific findings in combination with significant behavior changes, especially sexualized behaviors, but child unable to give a history of abuse.
      1. Periurethral bands.
      2. Longitudinal intravaginal ridges or columns.
      3. Hymenal tags.
      4. Hymenal bump or mound.
      5. Linea vestibularis.
      6. Hymenal cleft/notch in the anterior (superior) half of the hymenal rim, on or above the 3 o'clock to 9 o'clock line, patient supine.
      7. Estrogen changes.
      8. Septate hymen.
      9. Failure of midline fusion.
      10. Diastasis ani.
      11. Perianal skin tag.
      12. Increased perianal skin pigmentation.
      13. Redness of the vestibule or perianal tissues.
      14. Increased vascularity of vestibule.
      15. Labial adhesion.
      16. Vaginal discharge.
      17. Condyloma acuminata in a child under 2 years.
      18. Anal fissures.
      19. Flattened anal folds.
      20. Anal dilatation with stool present.

21. Venous congestion or venous pooling in perianal tissues.

b. Condyloma acuminata or herpes type I anogenital lesions in a prepubertal child in the absence of a history of abuse and with an otherwise normal examination.

c. Child has made a statement, but it is either not sufficiently detailed, given the child's developmental level, or is not consistent.

d. Findings concerning for abuse (these have been noted in children with documented abuse, and may be suspicious for abuse, but for which insufficient data exists to indicate that abuse is the only cause) with no disclosure of abuse or behavior changes.

1. Enlarged hymenal opening: a measurement of the transverse, horizontal opening of the hymen which is greater than 2 standard deviations above the mean for age (see J McCann et al, 1990).
2. Immediate and dilatation of at least 20 mm with stool not visible or palpable in rectal vault.
3. Hymenal notch/cleft in the posterior (inferior) portion of the hymenal rim.
4. Condyloma acuminata in a child over 2 years of age.
5. Acute abrasions, lacerations, or bruising of labia or perihymenal tissues – history is crucial in determining overall significance.

NOTE: Normal physical findings are the rule rather than the exception in childhood sexual abuse. The lack of either specific or nonspecific findings should never be taken as evidence that abuse did not occur. Genital tissues are elastic and may be penetrated without injury even if the child reports that the abuse was painful. If actual injuries do occur, they may heal rapidly. Superficial perianal injuries may heal in a few hours or days, deeper injuries in a few weeks. (See McCann and Voris, 1993). Even in cases of perpetrator-acknowledged vaginal penetration, up to 39% of girls may have normal or nonspecific findings (Muram, 1989). Rubbing of the penis against the inner surfaces of the labia, so called "dry intercourse," is a form of genital penetration which may result in transient or no physical findings. (See also Kerns and Ritter, 1992, who noted 61.5% of girls with acknowledged digital penetration had normal findings). When an exam yields normal findings, it is always correct to report "These findings are consistent with the diagnosis of sexual abuse" or "Anything which may have happened has left no marks."

4. Oral findings
   - Unexplained erythema or petechiae of the palate may be seen after forced oral sex.
   - Sexually transmitted infections may be seen (syphyilis, condyloma) or cultured (gonorrhea, chlamydia) with the oral cavity.
5. Somatization
   - Headaches.
   - Abdominal pain.
   - Encopresis.

- Wetting.
- Dysmenorrhea.
- Eating disorders (especially bulimia).
- Conversation reactions.
- Hysterical seizures.

6. Behavioral signs and symptoms: see above under "A. General…" plus
   - Explicit sexual language, play or drawings.
   - Sleep disturbance.
   - Difficulty with relationships as an adult, especially trouble with intimacy.

NOTE: Some sexual behaviors in children are clearly normal (preschoolers playing "doctor") and some clearly abnormal (adolescents causing genital injury to others). Sometimes it can be difficult to distinguish between normal and abnormal behaviors. Consider age differences and whether coercion was used. See Friedrich et al, 1998.

E. MUNCHAUSEN'S SYNDROME BY PROXY

1. Criteria for diagnosis (see Rosenberg, 1987)
   - Illness that is faked or produced by the caretaker.
   - The child is repeatedly presented to the HCP for medical care.
   - The caretaker denies knowledge of the etiology of the illness.
   - The symptoms abate when the caretaker is separated from the child.
2. Other features
   - The involved parent is almost always the mother.
   - The perpetrator is typically familiar with medical terminology.
   - S/he usually spends a lot of time with the child during any hospitalizations.
   - S/he is characteristically friendly and supportive of the hospital staff.
   - The most common symptoms reported are bleeding, seizures, CNS depression, apnea, diarrhea, vomiting, fever, and rash; failure to thrive is found in 14% of cases.

F. DISORDERS SOMETIMES MISDIAGNOSED AS CHILD ABUSE

1. **Dermatologic:** lichen sclerosis (causing a halo of abnormal-appearing skin around the vagina and anus), bruising and/or petechiae caused by nontraditional medical therapy (coin rubbing and cupping), mongolian spots, xeroderma pigmentosum (extreme susceptibility to sunburn), the congenital bullous disorders (extreme susceptibility to minor skin trauma with scar formation).
2. **Urologic**: urethral prolapse.
3. **Hematologic:** reduced number of platelets (e.g., ITP) or reduced platelet function; other clotting disorders.

4. **Neurologic:** Lesch-Nyhan disease (self-mutilation).
5. **Orthopedic:** osteogenesis imperfecta (particularly when the classic findings of blue sclerae, growth failure, radiographic evidence of osteopenia, and positive family history are not present, as can (rarely) occur.
6. **Other:** poverty (limiting access to care).

EVALUATION IN THE HOSPITAL EMERGENCY DEPARTMENT

Every hospital emergency department should have protocols for the handling of child abuse and neglect cases. Included in these protocols should be:

1. A system for reporting all cases of suspected abuse or neglect to the Division of Children, Youth and Families (DCYF) and/or the police.
2. A system to assure the child's safety after leaving the emergency department. This decision can be made with the assistance of DCYF and/or the police. For example, the alleged perpetrator should not have access to the child due to living arrangements or unsupervised access to the child's home.
3. A designated system for triage of suspected or stated cases of abuse or neglect. Cases in which sexual abuse/assault occurred within the preceding 5 days should be considered a medical emergency and evaluated as per the Attorney General's Sexual Assault Protocol. Cases in which the abuse/assault occurred more than five days prior to presentation should be considered non-acute and every effort should be made to schedule an appointment with the child's health care provider or with a provider in the CARE Network. (See Appendix N).

Issues that require immediate attention in the emergency department in non-acute cases include:

- The child is showing signs/symptoms of a sexually transmitted infection or a urinary tract infection.
- There is concern that the child might be pregnant.
- The child or the caretaker is emotionally distraught or showing signs of impaired coping.
- There are other injuries that require evaluation and treatment.

NOTE: The importance of tracking the follow-up of non-acute cases referred out of the emergency department cannot be overemphasized. If a child is referred for follow-up to another health care provider, emergency department personnel are responsible for making sure that the follow-up occurred.

4. The name(s) of physicians and nurses willing to evaluate infants or children who have been abused (e.g., a list of male and female providers willing to be called in for those cases of sexual abuse in which the child requests someone of a particular gender; the list could include physicians, nurse practitioners, and Sexual Assault Nurse Examiners (SANE).)

5. Expected duties of the emergency department staff nurse involved in the case:
    - Observation of parent-child interaction.
    - Recording verbatim of statements made by each.
    - History taking.
    - Preparing the child and the parent(s) for the examination.
    - Assisting during the examination.
    - Raising the issue of domestic violence with the child's caretaker.

NOTE: If the New Hampshire evidence collection kit is used, the nurse assigned to the case must remain in the examination room until the kit is sealed at the conclusion of the exam.

6. A designated room for interviewing children and parents, and a designated room in which to do the examination.
7. A list of necessary equipment (this manual, an evidence kit if needed, adequate illumination and magnification, a Wood's lamp, adequate lab slips and equipment for gathering of specimens, including appropriate speculums. NOTE: The list should NOT include anatomically correct dolls as these are not appropriate tools for emergency department use. (See section on anatomically correct dolls on page 15.)
8. Recommendations as to who should be present during the examination of the child (see chapter on THE NEW HAMPSHIRE MEDICAL ENCOUNTER FORM FOR CHILDREN (hereinafter known as The Medical Encounter, page 16).)
9. Recommendations as to how to maintain a confidential record.
10. A statement as to how the report to DCYF and/or the police should be made.
11. A plan to insure the release of medical information only to the appropriate authorities.
12. Patient information on Sexual Assault Crisis Center Services available in the community.

CONSENT

Only the parent or legal guardian of the minor child can give consent for medical care. If the parent or guardian cannot be reached in an emergency (defined as a condition which could potentially result in the loss of life or body function), the HCP may go ahead and treat in good faith, and the parent or guardian should be contacted as soon as possible. The HCP should also obtain the child's consent for an interview, examination and treatment. The HCP might explain "I would like to check you to be sure everything is OK. If there is something that you don't want me to do, then ask me to stop and I will." (See the section on The Medical Encounter, page 16).

If DCYF has custody of a child and has placed that child in a foster home, the parent or guardian still must give consent for medical treatment. Foster families should have a permission slip signed by the child's parent or guardian allowing routine medical care. This would allow, for example, treatment for otitis but not surgery for appendicitis. If the foster parent has forgotten the permission slip, the HCP should contact the parent or guardian by phone. If this cannot be done, the HCP should call the DCYF worker on the case. If DCYF is assessing a case of suspected abuse or neglect, the provider may diagnose and treat the child according to usual

medical practice without specific parental or guardian consent. It is still common courtesy, however, to contact the child's parent or guardian to explain who you are, that you are seeing the child, and that you have indicated to the DCYF worker that you advise specific tests be done and certain treatment rendered.

If a child is brought to a HCP for possible abuse or neglect unbeknownst to the parent or guardian and the child's safety is in danger (e.g., a child with a fracture is brought to the emergency room by a teacher who fears that the parent will become assaultive if he or she finds that the child is being treated there), the HCP should contact DCYF or the police for permission to proceed with medical care.

Children under the age of 18 may not legally consent for care on their own unless:

- They are emancipated (married, in military service, or living independently from parents or guardian)
- They are at least 12 and seeking medical care for substance abuse.
- They are at least 14 and seeking medical care for a sexually transmitted infection.
- They are seeking emergency treatment for sexual assault. An adolescent in this category who wishes not to notify her parents of what happened should be informed that if she is under the age of 18, it is mandatory that the health care provider notify DCYF and the police. Many adolescents who initially express a desire to keep the assault a secret from parents may readily disclose the assault to them when supported by a sensitive professional. Referral for such support should always be made for minors who have been assaulted.

Adolescents over the age of 18 may generally determine whether their parents or the police are to be notified of any sexual assault or injury, although they should be encouraged to cooperate with law enforcement. Exceptions to this rule are:

- If an adolescent is "thought to manifest a degree of incapacity by reason of limited mental or physical function which may result in harm or hazard to himself or others" or is chronically dependent on others to manage personal, home or financial affairs should have any injuries reported under the Protective Services to Adults statute, RSA 161-F:46 to the Division of Elderly and Adult Services at the local district office of the Department of Health and Human Services.
- An adolescent over the age of 18 who has received a gunshot wound or other serious bodily injury (defined as harm to the body which causes or could cause severe, permanent or protracted loss of or impairment to the health or of the function of any part of the body) must have the injury reported to the police. An exception is that under federal law, records of the identity, diagnosis, prognosis or treatment of a patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment or rehabilitation which is conducted or directly or indirectly assisted by any federal agency are confidential and may be disclosed only with a court order.

In all other cases not covered above, if the HCP is concerned for a child's safety or is suspicious that the child has been abused or neglected, DCYF or the police should be contacted for permission to treat.

Because issues surrounding consent and reporting are closely related, the HCP is encouraged to review the section on reporting which begins on page 23.

TAKING A HISTORY
(Interviewing Parents, Children and Adolescents)

A. EXPLORING THE POSSIBLE DIAGNOSIS OF ABUSE/NEGLECT

The HCP who is concerned that a child presenting for treatment might have been abused or neglected will need to ask questions that will help rule this possibility in or out. However, the HCP is not a detective and should leave extensive interviewing to others. Because raising the question of abuse or neglect is upsetting to parents, if there is someone available to provide support to them, such as a hospital social worker, s/he should be involved early on.

Generally speaking, it is preferable to interview the parent(s) and child(ren) separately and individually.

During the course of these discussions, a parent may suspect that the HCP is considering the diagnosis of abuse and neglect, feel threatened and become upset. To defuse such situations, it is helpful for the HCP to be frank about any concerns. This can be done in a way that allies the interviewer with the parent. For example, the HCP might ask the parent a question such as "Do you have any concerns that this injury might not have been an accident?" or "Do you think that someone might have lost their temper with him/her?" This kind of dialogue makes it clear that even though abuse is a consideration, the interviewer is not directly accusing the parent and in fact, acknowledges that the parent may have additional helpful information to help sort things out.

If a referral to DCYF or the police is inevitable, it is still preferable to engage the possibly abusing parent as an ally. The HCP might explain that the DCYF worker or officer "will help to figure out whether someone might have caused this injury" and perhaps add that "this is something that I'm not trained to do." Reminding a parent that like them, the HCP is interested in "doing what's best for your child" will often cool a rising temper. It is also helpful to explain that the HCP is required by law to report any situation that raises the suspicion of abuse or neglect. For example, you might say "I am required by law to report any situation that raises even the suspicion that an injury was not an accident. I hope you understand."

The sad truth is that most children who have been abused and/or neglected were mistreated by their caretaker(s). However, many of these caretakers end up successfully reunited with the child. Anger management, parent support, access to community resources, and improved living conditions assist large numbers of formerly abusive and neglectful parents in making a permanent change in how they handle their children. Thus, even when

you are certain that someone was the cause of a child's injury, remember that there is hope for improvement in that family and you may continue to provide their care in the future. Be careful about what comments you make either verbally or in the medical record.

If admission to the hospital is necessary to assure the safety of a child, it is easier to get the parent(s) to agree if there are also clear medical indications for admission (e.g., a child needs traction for a fracture). If hospitalization is required because the etiology of an injury or medical problem is unclear or because it is the only way to assure the child's safety, the HCP should use judgment in how this is explained to a possibly abusive or neglectful parent. Parents who refuse to permit hospitalization and threaten to remove the child should be given an opportunity to express their concerns and work cooperatively with the staff. In extreme situations, it may be necessary to contact security or call the local police.

B. GUIDELINES FOR FACT-FINDING

1. **Background:** With whom does the child live? Who provides the child care? (See Dubowitz and Bross, (1992)).
2. **The Event:** Who was there? Who witnessed it? Where did it occur? What was the child doing? When did it occur? Who is (are) the alleged or possible perpetrator(s)?
3. **The Disclosure:** Who spoke first, and to whom? What did the child say, and to whom? What have others said? Which agency was notified?
4. **Treatment:** What signs and/or symptoms have been noted, and by whom? Who sought medical attention, and from what institution or person? What has been done?
5. **Other Victims:** Who else was victimized? Other children? A caretaker? (When you see child abuse, be on the alert for spouse abuse as well as these frequently co-exist.)

C. TAKING A HISTORY WHEN A PATIENT IS REFERRED FOR POSSIBLE ABUSE OR NEGLECT

Before beginning, be sure you have adequate consent from the child and the appropriate adult(s) involved in the child's care (see previous section). Interviews should be held in a private, comfortable setting with no interruptions. Introduce yourself and explain your need to know what happened. Be sure the child understands that you need to find out what *really* happened: when someone gives you a truthful history in the course of a medical evaluation, the statements are admissible in court, unlike most "hearsay" evidence (see chapter on The Health Care Professional in Court, page 28). Offering that you have talked with other parents or children who have had problems like this will help ease their feelings of being the only one who has ever been through the experience.

The purposes of the medical interview are to obtain a general medical history and obtain enough specific information to conduct an appropriately thorough medical exam (with collection of pertinent physical evidence). A more thorough, detailed investigative history will be obtained by law enforcement and child protection agency personnel at another time.

If you are interviewing a child in foster care, the foster parent should bring along a copy of the form in Appendix F., page 45, which will include a general medical history.

When you then turn to questions about the reason(s) for the exam and what has happened to the child, separate interviews with the appropriate caretaker and then the child should be conducted. This way, any potentially upsetting history can be obtained without the child being present. Also, the parent (or other caretaker) may have concerns that he or she does not want to reveal in front of the child, and you will have the opportunity to address these issues and offer advice and support. Afterwards, the child should also have the opportunity speak alone with you. Even when the parent or caretaker was not involved in the abuse, many children are more comfortable telling what happened when a parent is not present. Sometimes children will want to talk to you about worries they themselves have about how their parents are doing. Certainly, if you know or suspect that the parent or caretaker was the perpetrator of the abuse, it is especially important to interview the child alone. The only exception to this rule is the case of the child who is frightened when separated from the parent. In this situation, ask as few questions as possible and leave the interview to a more experienced professional who can try later when the child is calmer.

The Medical Encounter Form (Appendix E., page 41) has space to record the general history, the reason(s) for concern about the child's well-being, and details of the maltreatment. Note that some general historical facts are eliminated from the main body of the report because they could be used to portray the victim in a negative light (e.g., history of sexually transmitted infections). The following chapter more fully explains how to record the history on the form.

D. TIPS FOR INTERVIEWING CHILDREN

1. Try to convey a relaxed, unhurried attitude.
2. Establish a rapport with the child before discussing the abuse by asking general information questions first.
3. Do not use terms like "honey" or "sweetheart" or tell the child she or he is pretty or handsome as these can be interpreted as seductive.
4. This is not the time to voice doubt about the child's veracity.
5. Do not assume that the child viewed the maltreatment as bad or painful or that the victim wants to be separated from the offender. The younger the victim, the less likely she or he will consider the abuse or neglect as wrong or unusual and the more likely she or he will experience the potential or actual loss of the parent as more traumatic than continued maltreatment.
6. Observe both verbal and non-verbal behavior.
7. Remember that seductive behavior is learned, sometimes as a way of appeasing an irrational and/or violent offender, sometimes as a way of getting attention and physical affection. Children are not born seductive and do not bring sexual abuse on themselves.
8. Do not use anatomically correct dolls since such interviews conducted by personnel untrained in their use can seriously damage a case (see below).
9. Wright down statements the child makes verbatim, in quotes, and note if the comment was spontaneous or a response to a question.
10. Use vocabulary that is age-appropriate, and use the child's own terminology, if any is volunteered. Ask for clarification of any unclear terms, e.g., "You said that he hurt your 'secret.' What is that?" or, "Can you show me where your 'secret' is?"

11. If the child is old enough to answer them, try to ask open-ended questions, such as "what happened next?"
12. Avoid asking "why" – e.g., "Why did you let him touch you?" – as this implies that the child could have acted in a "better" way.
13. Note whether restraints were used (actual or threatened) and whether the child resisted.
14. In closing, praise the child for cooperating and encourage the child's caretaker to provide positive reinforcement, e.g., "I'll bet your mother is very proud of what a good job you've done."

E. SPECIAL CONSIDERATIONS WITH THE ADOLESCENT VICTIM OF A SEXUAL ASSAULT

Adolescence is a complex phase in a child's development. It is a time when maturing children struggle to find their independence and identity and learn to form intimate, long-term relationships. Against these attempts to find one's own way in the world come pressures to conform and be like one's peers. Simultaneously, adolescents are learning to cope with the effects of hormones including rapid changes in their bodies and emotions. All of these developmental tasks are interrupted when an adolescent is sexually assaulted.

The healing process begins with the adolescent receiving medical and psychological treatment and with the adolescent taking part in his or her care. The initial emphasis should be on getting the most appropriate services and encouraging the adolescent to take as active a role as possible. This includes allowing the adolescent to choose where he or she is initially evaluated, how much medical history is related, who will be present during the examination and even whether the examination will be done at all. Patients over age 14 are legally entitled to confidential medical treatment for sexual assault, which means that parents do not necessarily have to be informed, but until a patient has reached the age of 18, any sexual assault must be reported to both DCYF and the police. In practical terms, this means that it is difficult to exclude parents from finding out about the assault. Most adolescents will find it best to inform their parents, sometimes with additional support from professionals treating them.

To encourage an adolescent to become a participant in the treatment process, the adolescent should have some time in a private interview. Taking some time alone with the adolescent will also facilitate a more accurate history of previous sexual experiences and risk taking behaviors. Discussions should be non-judgmental and should focus on concrete descriptions. Many adolescents are unfamiliar with the medical terms that providers use and are too embarrassed to ask for explanation; consequently, inaccuracies may appear in the medical record. Patience and flexibility are essential to a successful encounter.

Just as with younger children, adolescents should be assured that the assault was wrong and that they are not to blame for it. This message can be made clear even though the HCP may help the patient strategize ways to avoid assaults in the future.

Two common concerns of adolescent victims are the loss of virginity and fears that assaults by someone of the same gender will lead to homosexuality. The HCP should reassure patients that virginity is a state of morality, not of body integrity and that whether a person has a homosexual orientation is not determined by sexual victimization.

Parents may be a source of considerable strength and support or may compound the problems faced by an adolescent who has been assaulted. Parents' own feelings of guilt over why the assault happened to their child may cause them to be emotionally unavailable or rejecting of their son or daughter. Parents who forget that risk taking and experimentation are a normal part of adolescence may react with blame or anger when their child is assaulted after using alcohol or drugs, breaking a curfew or lying about where he or she was going. The HCP should be familiar with local agencies and individuals available for parental support in such situations.

THE USE OF ANATOMICALLY CORRECT DOLLS

Health care professionals are called upon to record observations, provide diagnoses, render treatment, and refer suspected child abuse and neglect to DCYF. The actual assessment is then conducted by DCYF and law enforcement. The use of anatomically correct dolls should be left to the professionals in these two agencies who have been specially trained in their use. There are several reasons for this. If the dolls are used incorrectly, erroneous information may be obtained. Also, a child may subsequently refuse to use the dolls either in a diagnostic interview or in therapy. Finally, once the child has been exposed to them incorrectly, any subsequent statements could be affected, and the entire investigation could be tainted. Many cases of abuse have been thrown out of court because of the well-meaning but misguided use of these dolls.

THE MEDICAL ENCOUNTER

A copy of the Medical Encounter Form can be found in Appendix E. This form was developed to assist the HCP in performing a concise, complete and legally sound medical report.

Before beginning, consent for the exam (including photodocumentation) should be obtained as described on page 10.

A. ENVIRONMENT

Even when the medical evaluation is performed as an emergency, the HCP should make every effort to convey a relaxed attitude to the child. It is helpful to select a quiet, comfortable room for the evaluation. Children who are used to an office setting may be most at ease there. When evaluating a child in the emergency department, it is sometimes more comfortable to start by using a small conference room to talk with the child and the family and move later to the exam room, explaining that you will need to use the special lights and equipment there.

B. INTRODUCING THE ENCOUNTER

Many children are brought to the evaluation either misinformed or unprepared. It is helpful to ask the child what s/he has been told beforehand and what s/he is expecting will happen. You might also invite the child to bring up his/her own concerns: "Is there anything special you want me to check for you, anything that you were wondering about or worried about?" You can explain that you have seen children for these sorts of reasons before, to reduce the child's feelings of being the only one to whom this has happened. Take any concerns seriously.

Tell the child that you are going to examine her or him from head to toe (particularly when a detailed exam is conducted because of a question of sexual abuse, this comment helps to de-emphasize the genital exam). It is appropriate to point out that you will try to minimize any embarrassment the child may experience.

Especially take the time to explain any procedures you will be doing that might be new to the child, such as an X-ray. You can often encourage a passive child to become more of a participant in the evaluation by explaining that you "need help" and asking him or her to be your "helper" by holding things for you or adopting a particular position to make it easier for you to see things. Similarly, photodocumentation can be explained as something you need to "help remember how things look."

A brief walk-through can do much to alleviate fears, expressed or internalized. Allow the child to see and handle any equipment and explain what sensations she or he may have when you use it. Depending on the age of the child, you might say, "See how this Q-tip feels a little cold when it's wet with some water?" Letting younger children put on a pair of exam gloves is a good way to show them what they feel like and how your hands will feel to them when you're wearing your own pair.

Do not volunteer that the exam "will not hurt," as the child may then start to worry that it will. But by all means, if the child brings up the question spontaneously, be reassuring about the parts of the evaluation that will not hurt. If a painful procedure cannot be avoided (e.g., a blood test), make liberal use of local anesthesia and be honest about what the child will experience.

The child should be invited to select someone as a companion during the exam. Whoever is named should be excluded only if they themselves are too upset to be helpful. For those who are uncertain about how to be supportive to the child, you can give simple instructions about what to say or do: "Your Mom is going to sit right next to you over here and hold your hand like this..." Generally, abusive parents should be excluded for the evaluation, although there are children who will be able to tolerate the exam only if that parent is permitted to stay.

C. DURING THE EXAM

The child should be given as many choices as possible ("Do you want to climb up on this table yourself or would you like a boost?") to increase his or her sense of participation and control. A choice of what position to assume during the exam is especially important. Make every attempt to avoid the position the child was in during the abuse (if known). Ask the child whether the position you suggest is comfortable or whether s/he would rather assume another.

Explain and then honor the "stop" rule. This rule says that if the child doesn't want to continue and says "stop," you will immediately comply and not proceed again until the child says "OK." You can demonstrate what you mean by rehearsing what to do if the child doesn't want you to look in his or her ear. Many abused children have been lied to, deceived or restrained even when they ask the perpetrator to "stop". Using this rule will help them understand how your evaluation is different. Once children see that you will honor the "stop" rule, they will usually permit even difficult exams to be completed. In an extreme case, consider an exam at a later time when the child is calmer or consider sedation or anesthesia if the exam must be done immediately.

Be careful with your word choice when describing what you are looking for during the exam. Words like "tear" or "cut" can sound scary to children and can reinforce any worries that they

have been damaged. Try to put things positively, for example, "I am looking to see that everything is okay here." In place of "germs" or "bugs" which imply that something is living in or on them, tell children you are "making sure everything is healthy."

D. STEP BY STEP THROUGH THE EVALUATION FORM

1. **Identifying data:** This information helps to clarify how you came to perform the evaluation, reminds you to obtain proper documentation and consent, provides updated information about how to contact the child's family and/or guardian and make reporting easier. All pages of the form should be labeled with the patient's name and date of birth for proper identification.
2. **History:** It is helpful to record the history you are given as a direct quote whenever possible. Note who was present when their history was given, e.g., "History obtained from mother, with maternal grandmother present; child in the waiting room."
3. **Physical examination:** This section begins with growth parameters to assess the child's physical development. If the child volunteers a cause for any given lesion (e.g., "my sister bit me there yesterday when we were fighting"), record the comment. Measure all bite marks as size can help distinguish between bites by children and those by adults. A Wood's light is invaluable for identifying possible sites on the skin or clothing where semen might be found, but remember that other substances also fluoresce (e.g., petroleum jelly). The child should be asked if "anything hurts anywhere." All part of the body should be palpated for tenderness, particularly the long bones, ribs, and skull.
4. **Ano-genital examination:** Note whether the exam was performed with the unaided eye or with magnification. A colposcope equipped with a camera allows the recording of acute pathology and makes it easier to get another opinion about transient or questionable findings. If you do not have access to one, remember that almost never are significant findings missed by a trained observer using a simple hand-held lens instead of an expensive colposcope.

Sexual maturation should be noted using Tanner staging (see APPENDIX C).

Try to have the child relax as much as possible when you note the dimensions of the hymeneal opening. Do not rush, move slowly, and ask her to let her muscles "get all nice and loose – like jelly." Waiting briefly before measuring will often result in a more accurate exam because as the patient relaxes, the hymeneal opening becomes less constricted by muscle tension. Be sure to note the position(s) of the child during the measurements since vertical and horizontal dimensions can change significantly with changes in position.

When examining the anus, again try to get the child to relax as much as possible and wait a minute or two for maximal dilatation to occur. If dilatation is present, be sure to note whether stool is present in the ampulla since this is a cause of anal gaping.

E. STUDIES AND EVIDENCE COLLECTION

1. **Evidence kit:** In cases of acute (less than five days) assault with penetration or ejaculation, a New Hampshire Sexual Assault Collection Kit should be used. Completing this kit requires familiarity with the Attorney General's Sexual Assault Protocol. It is

helpful to borrow a kit from a local emergency department and review it with your staff before you find yourself faced with your first case in which an evidence kit is needed. Because the kit was designed for adults, it may not always be appropriate to use it without modification for a child. If you are examining a child under the age of 12, you may elect to replace the reporting forms in the kit with the one specifically designed for children that is found in APPENDIX E. In such a case, you should keep a photocopy of the form for your own records on the patient.

If a sample is to be obtained for condom trace evidence (which helps to determine whether an assailant used a condom), it is critical that the examiner use powder free gloves to avoid contaminating the sample.

During the anogenital examination, samples to obtain and return to the evidence kit if one is used include:

a. Two dry swabs each of the vagina and rectum (or only of the rectum in male patients), air dried and returned to the evidence kit to look for condom trace evidence.

b. Two dry swabs each of the vagina (where the best site is the posterior fornix) and rectum to look for evidence of semen. These samples are first smeared on a slide which, with the swabs themselves, is returned to the evidence kit.

NOTE: The prepubertal female will likely not tolerate dry swabs being used to collect samples from the vestibule or vagina because of discomfort. Swabs premoistened with nonbacteriostatic saline are a better choice.

Alternatively, you can aspirate any fluid in the vagina with a bulb syringe or plastic tube connected to a syringe. Soak this fluid into two dry swabs, prepare an air dried smear, dry the swabs, and include the slide and swabs in the evidence kit.

c. Two swabs moistened with saline or water and thoroughly wiped across all surfaces of the inner thighs, and then smeared on a slide which, with the swabs themselves, are air-dried, and returned to the kit. Similarly, a second set of two moistened double swabs should be wiped across the buttocks, a third set over the perineum in females and scrotum and penis in males, and another set over any other suspicious areas (e.g., where Wood's fluorescence is noted).

d. Two swabs wiped around the interior of the mouth where the best sites are the spaces between the gums and the cheeks.

2. **Bacteriology studies:** In addition to the evidence collected and returned to the evidence kit, samples to be collected and processed by a local laboratory may include:

a. Gram stains of any urethral, vaginal, and rectal discharges.

b. Cultures for gonorrhea of the urethra in males (or meatus only if discharge is present), endocervix in pubertal females, vagina in prepubertal girls (use a swab moistened with NONBACTERIOSTITIC saline since a dry swab is painful if the child is prepubertal), and rectum and pharynx in both sexes. Positive gonorrhea cultures should be confirmed by a second reference lab.

c. Cultures (NOT rapid identification techniques, such as slide or DNA tests*[Microtrak R, Chlamydiazyme R and GenProbe R] which are neither adequately tested nor FDA approved for use in children) for chlamydia of the urethra for males, endocervix for

pubertal females, vagina for prepubertal girls, and rectum for both sexes. Use a cotton swab on a plastic applicator, moistened with NONBACTERIOSTATIC saline for the prepubertal girl's comfort. Do not use a calcium alginate swab or a swab on a wooden applicator stick as these are toxic to chlamydia and can cause a falsely negative culture.

***NOTE: Routine genital tract culturing of adolescents who have experienced intercourse is recommended because of the high rate of asymptomatic infection. The decision to do rectal and pharyngeal cultures should be made based on symptoms, the time since sexual contact and the contact's status (if known). Prepubertal children should be cultured if they have symptoms, if the sexual contact was so recent that symptoms would not have had time to appear or if they have had sexual contact with a known carrier; routine cultures are not indicated.**

d. A wet prep of any vaginal secretions to be immediately examined for trichomonas.

e. A swab of vaginal fluids to test for bacterial vaginosis as suggested by a pH of 4.5 or greater, the presence of "clue" cells seen when a slide is examined under the microscope, and a "fishy" odor produced when potassium hydroxide is added to a smear.

f. A viral culture of any vesicles.

g. A biopsy of perineal warts should be considered for typing, since some viral types are characteristic of sexual contact as compared with autoinnoculation. This requires advance planning and anesthesia. A consultant with expertise in child sexual abuse can be helpful in making this decision.

3. **Photographs:** These should be taken by a trained forensic photographer or (if available) by the examiner using a specially equipped colposcope.

4. **X-rays:** are indicated for any bones exhibiting tenderness or deformity. A full skeletal survey (AP and lateral views of skull, axial skeleton, arms, forearms, hands, femurs, lower legs and feet) is indicated for all children under 2 with suspected physical abuse and may be considered selectively for children between the ages of 2 and 5. A bone scan may supplement plain films and show rib fractures, shaft fractures and early periosteal elevation that might otherwise have been missed. However, a bone scan is not an appropriate primary study. Plain films of the skull to look for fracture should be considered in infants with a scalp laceration, contusion or abrasion.

An MRI or CT "is recommended for all children with suspected intracranial injury as evidenced by altered mental status, focal neurologic deficit, signs of a basilar skull fracture, or seizure, and should be considered for neurologically normal children with a history of loss of consciousness, vomiting, headache, drowsiness or amnesia. Infants with an identified skull fracture warrant in-hospital observation, head CT, or both." (Quayle et al, 1997). Use of the MRI for diagnosis should be limited to situations in which: 1) clinical findings are not explained by CT findings (since MRI is more sensitive than CT for finding subdural hematomas, cortical contusions, cerebral edema, and white matter injuries); 2) determining the age of hemorrhage is critical; or 3) the "shaken child" syndrome is suspected (Am Aca Ped, Section on Radiology, 1991).

Imaging of the chest and abdomen in significantly injured children should follow guidelines for any major trauma with CT being considered for more definitive soft tissue examination. Elevated liver transaminases may help to identify the abused child with occult liver injury.

5. **Urinalysis and culture:** These are indicated if a urinary tract infection is a consideration or if abdominal trauma occurred.
6. **Toxic screen (urine):** In cases of acute assault, a toxic screen is indicated if there is concern that the victim was under the influence of drugs at the time. The patient must specifically consent to the test. The specimen should go to the police for processing by the state lab. If a STAT result is needed, send an additional specimen through the hospital lab. Testing for rohypnol, an odorless, tasteless, colorless drug often mixed in alcohol to produce sedation and retrograde amnesia (so that the victim does not remember that there even was an assault), requires a 6 ml urine and/or a 10 ml blood sample (see Studies and Evidence collection, page 18). The drug is detectable in urine up to 4 days after ingestion and in blood 24-48 hours afterwards. The samples should be mailed to National Medical Services, 3701 Welsh Rd., Willow Grove, PA, 19090, 1-800-522-6671.
7. **Blood work:** Clotting studies may be indicated if the child has unusual bruising or bleeding. A pregnancy test is indicated in pubertal girls with a history of penetration in the past or in whom there is a suspicion of pregnancy even in the absence of a history of penetration. Remember that pregnancy can occur even in the absence of a first menstrual period. A serological test for syphilis and test for hepatitis B should be considered on children or adolescents who have a known or questionable history of penetration. An additional sample of serum may be obtained to store, frozen, in the hospital lab as a time "O" sample if HIV testing is to be done (see Appendix H). A 3-cc sample of blood for typing is submitted to the police if the evidence kit is used.
8. **Summary/Impression/Plan:** Record your overall impression in this section. Also record any surgical treatment (sutures, for example) in the space provided and attach a copy of any operative note. Consider antimicrobials for STI prophylaxis including the HIV virus (consult your local infectious disease specialists for the most recent recommendation). Determine whether the patient needs tetanus prophylaxis for possibly contaminated wounds and HBIG for hepatitis B exposure. Follow the recommendations regarding pregnancy prophylaxis. Make a referral for mental health. If the child is placed in foster care, obtain the foster parent's name, address and phone number. If the child was admitted to a hospital either for treatment or for reasons of safety, this should also be noted. If the evidence kit was used, indicate which of the forms in the kit you have given to the child or responsible accompanying adult and, if pregnancy prophylaxis was given, fill out the form in the evidence kit. Record any other instructions given.
9. **Explaining results of the examination to the parent(s) and child:** Parents are often very concerned about the results of the examination and will want an explanation immediately afterwards. After a summary of your findings and impression, it is helpful to ask parents what, specifically, they were wondering about or worried about. This allows further discussion about those points that are most important to them. Particularly when there are no significant physical findings (as is most common in cases of non-acute

sexual abuse), it is important to tell them than the absence of findings does not mean that nothing happened, merely that anything that might have happened has left no marks. Parents can readily understand the concept that some tissues are resilient and resist signs of injury (e.g., not all falls cause bruises) and injured tissues heal rapidly without necessarily leaving a mark (e.g., some cuts heal without scarring). Many parents will be surprised at how their child has reacted to a traumatic event(s) and will need an explanation of the varieties of coping mechanisms that they may see. The post-exam conference is also a good time to stress the importance of a mental health referral in order to deal with emotional reactions, particularly those that may be delayed or maladaptive. Finally, offering a written report of your findings, impressions and recommendations may be very helpful to parents. Some will want a copy of the report you send to DCYF while some will find a report written especially for them more understandable.

Depending on the child's developmental level, a discussion about what you saw and what it means can be very helpful as well. A good place to begin is to compliment the child on how well s/he cooperated with the exam. As you did with the parent(s), specifically ask what the child is wondering about or worried about the findings. It is helpful to reassure the child about how healthy and normal his or her body is. Even if you noted a physical change in, for example, the child's genitalia, it is always useful to mention that even though you can see a sign, using your special instruments, that something happened, nothing is "broken" and everything "works OK". For children with no familiarity with the concept of mental health therapy, you can briefly explain that children who have had similar things happen to them find it helpful to talk with someone about how they are doing. Finally, many children appreciate having a report from you about the visit written at their level. This can be read with the parent, shared with the therapist and referred to in the future. The report can be just a few sentences, stressing how brave and cooperative the child was and how this helped you do your job to be sure everything was healthy.

10. **Agencies notified:** Include in this section the names of any persons you contacted at the local DCYF office, police, and any other agencies. Remember that some sexually transmitted infections must be reported to the New Hampshire Division of Public Health Services, Bureau of Disease Control (see Appendix G).

11. **Follow-up:** The health care professional will need to make decisions about appropriate medical follow-up for children, taking into account any injury(s) and the child's health status. In cases of acute sexual assault, a telephone call the following day is helpful to be sure the patient is improving and getting any indicated treatment. The mere fact that a concerned health care professional took the time to call can go far to provide needed support to a stressed child and/or family. An appointment in several days is indicated to discuss recovery (emotional and physical), assess the status of any wounds, and perform follow-up cultures if new symptoms have occurred. After two weeks, follow-up cultures are obtained if an initial culture was positive, or if the child did not receive prophylactic antibiotics at the first visit. In such cases, another follow-up in six weeks is needed to obtain a follow-up test for syphilis and, if a menstrual period has not occurred since the assault, a pregnancy test. This is also a good time to ask whether psychiatric treatment has begun and to encourage the child to stay in therapy. Serologic studies should also be obtained according to standard protocols such as that suggested by the Centers for Disease Control which recommends that when repeating tests for syphilis, hepatitis B and HIV serology, they be obtained at 12 weeks. A final HIV titer can be drawn at 6 months.

Other follow-up appointments should be arranged depending on the individual situation. Because the HCP doing the initial evaluation may lose contact with a child who has been placed outside of the home, it is important to clearly communicate to DCYF what medical follow-up is indicated so that arrangements can be made for another HCP to provide the care.

PHOTOGRAPHING ABUSED AND NEGLECTED CHILDREN

The pediatric health care professional should not be responsible for routinely taking photographs of maltreated children. DCYF workers have cameras at their disposal for on-site photography (e.g., of the child's home environment or of acute injuries noted on a home visit). Local police departments either have on staff or have access to officers trained in forensic photography. The one situation in which the HCP might choose to take photographs is if for some reason it will not be possible to obtain photographs again before the child's appearance changes. Health care providers with access to a colposcope equipped to take videos or still photographs may record physical findings observed during the examination. Videos and photographs should be clearly labeled with the patient's name, an identifying number such as date of birth and the date of the examination.

PRESERVING THE INTEGRITY OF EVIDENCE

Objects that are used in the investigation and prosecution of a legal case are termed "evidence." Examples of types of evidence include blood samples, a victim's clothing or a written statement. To be sure that evidence is not tampered with, each item must be accounted for at all steps of the investigation. This accountability is assured by the so-called "chain of custody." Each piece of evidence is labeled and then moved from place to place according to specific legal guidelines. The path the evidence takes until its appearance in court is recorded on a sheet of paper that states what the evidence is and who handed it over to the next person responsible for its safekeeping.

Health care providers must ensure that the chain of custody remains intact for any item they handle. This means that forensic specimens should be labeled and sealed in a package that is opened only be a designated recipient. The evidence kit contains containers, labels, and a recording form for specimens obtained in cases of acute sexual assault. On the front of the kit is a form to record how the collected evidence was transported from the patient's bedside to the forensic laboratory while always kept secure to prevent tampering. The health care provider should be careful to follow recording procedures exactly in order to preserve the integrity of the chain of custody.

Medical samples sent to the hospital lab, such as cultures, do not need to be tracked using such a form. It is sufficient to follow usual hospital or office procedures for such samples, which includes standard labeling and reporting of results.

CONFIDENTIALITY OF MEDICAL RECORDS

Because child abuse and neglect are sensitive issues, and because medical records, particularly those in a hospital, are available to many people (some of whom have no need to know details of a given case), it is best to limit comments made in the chart. Appropriate facts to record include: 1) that you have a concern that abuse or neglect has occurred; and 2) that a report has been made to the responsible social service agency. If the child has been hospitalized, it is important to write down whatever decision has been made in consultation with DCYF as to when the child can be discharged and where the child should go.

Further details should be kept in a confidential file. The confidential file would include material from the body of the hospital chart as well as the emergency room encounter form (as is done in adult cases in which the evidence kit is used). These records should be sealed in an envelope and marked with the patient's name, date of birth, and medical record number. The confidential file should be locked and accessible to as few people as possible. Ordinarily it is stored in the medical records department. Individual hospitals may have protocols for the storage of such material and the health care provider is encouraged to ascertain what the local hospital guidelines are.

Remember that medical records are the property of the patient and his or her parents. It is likely that at least some family members will eventually see what you have written. Therefore, be careful not to make comments that might be perceived as derogatory.

When coding a patient visit at the time of the encounter (as is required by insurance companies) it is best to avoid the diagnosis of "abuse" or "neglect" since these conclusions often cannot be made until after an investigation has been completed. Instead, use the modifier "rule out" or else use whatever code is appropriate for the medical condition the child exhibits such as "fracture" or "vaginitis". The code V71.5, "observation after alleged rape," and V71.6, "observation after inflicted injury," may be used when children are referred to a physician participating in the CARE (Child Abuse Referral and Evaluation) Network (see APPENDIX N.)

The HCP should, as always, respect the confidentiality of patients and families in comments to colleagues and others.

Requests for information from the media can be tactfully handled by giving only general information about abuse and neglect and never discussing specifics about a given case. In individual cases, most hospitals can provide assistance by providing a spokesperson to address questions from the media.

REPORTING

Reporting of known or suspected abuse or neglect of children under the age of 18 is required in all states, including New Hampshire. Failure to report is a misdemeanor punishable by a fine and a jail sentence. In addition to these penalties, anyone who fails to report suspected abuse or neglect risks being named in a civil suit brought on behalf of the child or other victims, which may occur immediately, or not until many years later.

Child abuse and neglect are complex problems that require a multidisciplinary approach, one that cannot be accomplished by an individual working alone, even one acting with the child's and family's best interests at heart. Reporting starts the following chain of events:

1. It begins an investigation as to whether a child has, in fact, been abused or neglected.
2. It begins an immediate process by DCYF to protect the child at risk.
3. It begins an investigation to determine the nature and extent of the child's injuries and/or needs.
4. It allows child protective agencies to search for and, in many cases, identify the person(s) mistreating the child.
5. It leads to a search for other victims. For example, child sex offenders typically have many victims.
6. It enables child protection agencies to offer treatment to the child, the family, and the person abusing or neglecting the child.
7. It enables the agencies to follow through with treatment by invoking the power of law enforcement and the court system.

Regardless of whether a family knows or suspects that their child has been abused or neglected, the statement by a professional that the child has been identified as having been maltreated by someone almost always precipitates a crisis. Reactions are immediate, intense, and often unpredictable. Sometimes it is hard for the health care professional to keep a sense of perspective and continue to be a source of support and care for both the child and the family. It is essential to treat the parents or the caregivers of the victim in a non-judgmental manner; otherwise, they will likely become defensive and feel alienated.

The health care professional should make the protection of the child the first priority, and the assistance of the family a close second. As long as the family knows that your primary goal is the same as theirs – the protection of their child – you will usually be viewed as helpful. Remember that non-abusive, non-neglectful parents are typically consumed by guilt to learn that their child has been maltreated, and it is important to give no hint that there was something they could have done to prevent what happened. It is helpful to directly discuss feelings of guilt as a step to defusing their intensity. Referral to a counselor or to support groups may be appropriate.

A. HOW TO REPORT

A report should initially be made by phone to the Division for Children, Youth and Families.

1-800-894-5533

This should be followed within 48 hours by a report in writing, if so requested, to the bureau. The report should contain as much of the following information as possible:

1. The name and address of the child and the person responsible for the child's welfare.
2. Specific information indicating the type of neglect or the nature and extent of the child's injuries (including any evidence of previous injuries).
3. The identity of the person or persons suspected of being responsible for the maltreatment.

4. Any other information that might be helpful in establishing whether neglect or abuse occurred.

If you are unable to reach anyone at the phone number for your area, you should call the police in the town in which the alleged abuse or neglect happened. You should also notify the police if any child has been sexually abused or seriously physically abused, even if you have already notified DCYF.

DCYF will, on request, provide in-service training on how to handle abuse and neglect cases. Contact your local DCYF office for details.

B. WHAT TO REPORT

Any suspicion of abuse or neglect, whether physical, emotional, or sexual, in a child under 18 must be reported. In addition, if you have a suspicion of a new type of abuse or neglect who has already been reported, you must make a new report.

Furthermore, you are also required to report some types of violence to adults including gunshot wounds and serious bodily injury. For example, if a child is seen with a parent and both have been seriously beaten by the parent's partner, you must report both the child's and the parent's injuries to the police.

C. GUIDELINES FOR MAKING THE DECISION TO REPORT SEXUAL ABUSE OF CHILDREN

DATA AVAILABLE			RESPONSE	
History	**Physical Examination**	**Laboratory Findings**	**Level of Concern About Sexual Abuse**	**Report Decision**
None	Normal	None	None	No Report
Behavioral Changes	Normal	None	Variable, depending upon behavior	Possible report** follow closely possible mental health referral
None	Nonspecific findings	None	Low (worry)	Possible report**
Nonspecific history by child or history by parent only	Nonspecific findings	None	Intermediate	Possible report** follow closely
None	Specific findings***	None	High	Report
Clear Statement	Normal	None	High	Report
Clear Statement	Specific findings	None	High	Report
None	Normal, Positive nonspecific or specific findings	Culture for gonorrhea; positive serologic test for HIV; syphilis; presence of semen, sperm acid phosphatase	Very High	Report
Behavior changes	Nonspecific findings	Other sexually transmitted diseases	High	Report

* Some behavior changes are nonspecific, and others are more worrisome. See Krugman, 1986.
** A report may or may not be indicated. The decision to report should be based on discussion with local or regional experts and/or child protective services agencies.
*** Other reasons for findings ruled out.

From American Academy of Pediatrics, Committee on Child Abuse and Neglect, "Guidelines for the Evaluation of Sexual Abuse of Children," Table 1, *Pediatrics 103:* page 189.

D. GUIDELINES FOR THE EVALUATION OF SEXUAL ABUSE OF CHILDREN

STI CONFIRMED	SEXUAL ABUSE	SUGGESTED ACTION
Gonorrhea	Diagnostic	Report
Syphilis	Diagnostic	Report
HIV	Diagnostic	Report
Chlamydia	Diagnostic	Report
Trichomonas vaginalis	Highly suspicious	Report
Condylomia acuminata (anogenital warts)	Suspicious	Report
Herpes (genital location)	Suspicious	Report
Bacterial vaginosis	Inconclusive	Medical follow-up

1. If not perinatally acquired.
2. Use definitive diagnostic method: culture, not enzymatic assay.
3. To agency mandated in community to receive reports of suspected sexual abuse.
4. If not perinatally or transfusion acquired.
5. Unless there is a clear history of autoinnoculation, Herpes 1 and 2 are difficult to differentiate by current techniques.

From American Academy of Pediatrics, Committee on Child Abuse and Neglect, "Guidelines for the Evaluation of Sexual Abuse of Children," Table 1, *Pediatrics 103:* page 188, corrected, May 1999.

E. REPORTING SEXUAL ASSAULT IN PATIENTS OVER THE AGE OF 18

Recognizing the importance of being sensitive to the needs of the patient and the need to gather and preserve important physical evidence, the State of New Hampshire has established an Anonymous Sexual Assault Reporting System. This allows the patient who is unsure about whether s/he wants to report the crime to keep her/his anonymity until such time as s/he decides to report. Patients who present for medical care following a sexual assault should be assured that cooperation in collecting physical evidence will not obligate them to either release the evidence or pursue prosecution of their case. The patient should be told that the anonymous evidence kit will be turned over to the local law enforcement officer who will transport the kit to the New Hampshire State Police Forensic Laboratory where it will be stored for up to three months from the date of the examination. If the patient has not reported the crime to law enforcement, then the kit will be returned to the local police department for disposition. If the patient reports the crime, s/he will contact the law

enforcement agency having jurisdiction where the crime occurred. The kit will then be retrieved from storage and processed.

Patients should be told that if they do not have medical insurance the state will pay for the cost of the examination only IF the crime is reported to law enforcement.

PAYMENT

As a general rule, parents are responsible for the payment of their children's medical bills. Parents (or their insurance carriers) should be billed according to your usual office procedures. See section on Confidentiality of Medical Reports, page 23.

For CARE exams, DCYF should be consulted regarding payment for the visit.

If a child is in foster care, he or she may be automatically Medicaid eligible. Ask the foster parent if there is a Medicaid card.

As of April 26, 1988, **the State of New Hampshire is responsible for the payment of sexual assault medical examinations not covered by medical insurance or other third party payment when the examination is conducted for the purpose of collecting evidence. In order for victims to qualify under this law, the sexual assault must be reported to law enforcement.** If the patient is over 18, s/he should be asked whether or not s/he wants to report the assault to the police. If s/he is undecided at that time, refer to the Anonymous Reporting Procedure..

If the sexual assault is reported to law enforcement the victim should not be billed. If the patient has insurance, she should be told to submit all necessary forms to the hospital billing office and the insurance company will be billed. The patient should not be billed for any expenses not covered by the insurance company. If the patient has no insurance, the bill should be sent to:

Office of Victim/Witness Assistance
Attorney General's Office
33 Capitol Street
Concord, NH 03301
(603) 271-3671

NOTE: Sexual Assault Evidence Collection Kits can be re-ordered through the same office.

NEW HAMPSHIRE VICTIMS' ASSISTANCE COMMISSION

Victims of sexual assault may also be eligible to apply to the **New Hampshire Victims' Assistance Commission** for compensation of medical/dental expenses, mental health therapy expenses, lost wages or other out-of-pocket expenses not covered by insurance or other resources available to the victim. The compensation must be directly related to the victims' condition as a result of the crime. Property losses and pain and suffering are not compensable. In order to quality, the victim must report the crime to law enforcement.

For more information the victim should call:

1-800-300-4500 (toll free in NH only) or (603) 271-1284

THE HEALTH CARE PROFESSIONAL IN COURT

Although most cases involving child abuse and neglect are investigated and settled without the need for the health care professional to present legal testimony, occasionally such an appearance is necessary. The HCP may be asked to explain what statements the child made, to describe injuries or signs of maltreatment that were found during an examination, or give an opinion as to how an injury was produced. This testimony may be given one of two ways: at a deposition, which is a question and answer session attended by attorneys representing both sides of a case, and/or at a trial. In either situation, when you give your testimony, you are under oath, and a complete record of the proceedings is made by a court stenographer in writing or on tape. During a deposition, no judge is present but a judge will receive a transcription of the deposition later on (and retrospectively rule on any objections made during it.) If a case goes to trial after you have already given your testimony in a deposition, always review a copy of the transcription beforehand. You can obtain a copy from the attorney or prosecutor's office.

A case may be heard in one of several different types of court. Juvenile court is concerned with matters related to the protection of a child, such as where the child should be placed to ensure safety. Family court determines such issues as parental custody and visitation. Civil court is the site of trials which determine if a preponderance of evidence supports specific charges and, if so, determines the consequences and may award damages; matters related to whether a family neglected a child, for example, would be the focus in a civil trial. A trial in criminal court seeks to determine if a person committed a criminal act beyond a reasonable doubt. If a person were charged with the assault of a child, the case would be heard in a criminal trial. Each of these types of courts have different rules and protocols and you should consults with the attorneys ahead of time so that you understand how the case will be presented and what is expected of you when you testify.

Unlike the melodramatic scenes that television and movies may offer as "real life courtroom drama," most hearings are devoid of impassioned tirades and witness badgering. The justice system is interested in your testimony as a professional who took care of the child, and it may help ease any anxiety you may have about appearing in court to remember that the reason you are there is to help assure the best possible outcome for your patient. As the primary, and perhaps, the only HCP to directly examine the child in question, such an outcome cannot be attained without you. If you approach the experience calmly and fully prepared to explain your conclusion in layman's terms, justice will likely be served.

A. TIMING

If the circumstances of a given case of abuse or neglect necessitate your appearance in court, you will receive notification by mail or by telephone some time before the actual date. Usually this means several weeks. On some occasions, last-minute changes in the court's schedule may result in a change in your appearance date. One example would be what is termed a "continuance." A continuance is a postponement granted by the judge to one side or the other in an ongoing or pending trial. As much as possible, you will be kept informed of when the case

will actually be heard. The attorneys know you are busy and will try to accommodate your schedule as much as possible. Close cooperation with them is essential. Make sure lines of communication stay open by exchanging phone and fax numbers as well as e-mail addresses, if applicable.

In shaping courtroom strategy, attorneys strive to present their cases in a purposeful and coherent order. This approach will determine when in the course of a trial your testimony will be most helpful. The attorney conducting your direct examination should be able to tell you roughly how long the trial is expected to last and approximately when in the proceedings your testimony will be needed. Occasionally, HCPs are allowed to testify "out of turn" during the course of a trial, such as first thing in the morning, so that they may get back to their offices promptly.

Sometimes you can arrange to be available "on call" to the courtroom, which means that you will not need to wait at the courthouse, but can come just when your testimony is needed. Your responsibility is then to come without delay.

Your local Victim/Witness Advocate, who may well be the primary contact person for scheduling your testimony, is available to assist in scheduling problems and to answer any questions you may have regarding appearing in court.

B. DO I HAVE TO APPEAR IN COURT?

Yes. As a witness, your appearance in person is required. Videotaped testimony or answers submitted in writing are generally not acceptable. Usually, witnesses are notified in writing of the need for their appearance in a document called a subpoena which is typically delivered in person by a sheriff. A subpoena will tell you the specific time and place for your appearance but you should always call first to verify these details and, if you foresee a problem with your appearance, to let the court know. Witnesses who ignore subpoenas can be fined or jailed.

Beyond the legal requirement to do so, the compelling ethical argument to represent your own work is self-evident. No one knows the medical findings during your examination of a child at a particular time and place more intimately than you. To have these findings presented by a surrogate, or in such a way that you are isolated from the jury you are charged with informing, will shortchange your patient and, possibly, justice itself.

One way to help reduce the chance that you will be asked to testify in a trial is to keep meticulous notes on the cases you handle. You should assume each case you are involved in will end up in court and write up your notes accordingly. Clear descriptions of the clinical encounter and straightforward, understandable explanations of their significance will often eliminate the need for you to explain the patient's care in the court setting.

C. WILL I BE PAID FOR MISSING WORK?

No. As a witness, you are entitled to a nominal witness fee which is set by the county in which the case is tried. You may not bill anyone for the time you miss from your practice. A notable exception occurs when you are appearing as an expert witness. An expert witness provides more extensive information to the court about the meaning of medical findings. In such cases your fee will be worked out ahead of time with whatever party has hired you in this capacity. If you are asked during a trial "How much are you being paid for your opinion?" You

can correctly point out that you are not being paid for your opinion but for your time in reviewing, analyzing and explaining the case to the court.

D. HOW DO I PREPARE FOR A TRIAL?

First, you need to know why you have been asked to appear. Did you personally examine or care for a maltreated child? Did a child or parent make a statement to you that was cause for concern? Did the parent on one of your patients repeatedly demonstrate neglect of his or her child? Review all your records thoroughly to refresh your memory of the case so you can answer the questions readily and completely. Make sure you have seen all laboratory results and written reports on the child. As you get your thoughts in order, remember that your testimony should be the same whether you are testifying for the defense or the prosecution: you are presenting facts, not trying to slant the testimony one way or the other.

A pre-trial meeting is extremely important; many HCPs insist on them. The purpose of the meeting is not to rehearse your testimony but to establish clearly what specific issues are of the most concern and what you are likely to be asked. You can then be prepared to frame your remarks so that they provide the most useful information in the clearest possible language.

E. WHAT MATERIAL FROM MY RECORDS WILL BE NEEDED AT THE TRIAL?

A DCYF assessment of a case of abuse or neglect requires your full disclosure of any information you may have concerning the child's possible maltreatment. However, this does not require you to violate patient or parent confidentiality in other areas. If you have been asked to testify at a trial, you only should give information that pertains to the question of abuse or neglect unless a patient/parent has given written permission for you to present all records.

Sometimes the entire record may be subpoenaed which requires you to bring all records before the judge, whether the patient/parent has signed a release or not. The records are then reviewed by the judge alone, who decides what material should be disclosed at the trial. If you feel that there is material in your records that should be kept out of the courtroom because it is confidential in nature and does not pertain to any maltreatment issues, you should explain this to the judge. If you have a question about a confidentiality issue, it is wise to consult your own attorney for advice.

Educational materials such as graphs, charts or sketches using an easel and poster board are appropriate and valuable aids to testimony. As long as opposing counsel is made aware of their planned use, and is permitted to examine such materials in advance, there should be no problems with their use. Use of photographs or videos may or may not be admitted into evidence depending on the court. You should expect some discussion well before the trial about the possibility of using them.

F. WHAT ABOUT MY COURTROOM APPEARANCE?

It is perfectly appropriate to bring any charts, records, or notes with you to review just before you appear on the witness stand. Be cautioned, however, that any materials you bring with you to the stand will be reviewed and possibly photocopied, as both sides are entitled to the information. Be sure, therefore, that your notes are relevant to the trial, include no comments

which might be interpreted as inflammatory or prejudicial against anyone, and bring no material which should be held in confidence.

G. WHAT IS IT LIKE TO TESTIFY ON THE STAND?

You will be sworn in and your background reviewed. This involves giving personal data such as your name, address, education, professional experience and affiliations. (Review your CV for dates of degrees, and board certifications, membership in professional organizations, license, etc. Be sure everything is accurate). Submitting a copy of your CV to both attorneys is a standard pre-trial procedure that makes all parties familiar with your credentials and will streamline the process the day of your appearance. You may be asked if you have ever published any papers on child abuse or neglect. Do not be embarrassed to say "no" to this routine courtroom questions.

Everything you say will be taken down by the court reporter. Answer all the questions verbally since nods or gestures cannot be recorded. The prosecuting and defense attorneys will then each have a turn asking you questions. Let them complete each question entirely and then allow a little time before answering to allow for any objections. If an objection is made, do not answer the question; wait until the judge tells you whether to go ahead. It is certainly appropriate to take your time when answering a question. Give yourself time to think your answer through. Rapid responses imply that you are not careful or that you have rehearsed your reply. If you do not understand a question, do not answer it. Ask it to be repeated, rephrased or clarified. Occasionally, a second round of questions (re-direct and re-cross) may be asked before you leave the stand.

If the question concerns facts about which you have no personal knowledge, say so. In general, you should not testify as to what someone told you about the facts unless you are specifically asked. Anticipate an objection from opposing counsel if this happens. If you are asked about an event for which you have no memory, say so. Do not guess. If you do not know the answer to a question, say so. Nobody expects you to know everything. Be direct and concise in your answers and do not elaborate if a simple "yes" or "no" will do. On the other hand, if you wish to explain your answer and you are cut off, it is appropriate to say that you have not finished your answer so that later, opposing counsel can ask you to clarify your response.

Should you find a response you have previously given misstated or muddled by poor paraphrasing, do not hesitate to politely correct the error. For example:

Attorney: Now, you have testified that X, Y, and Z…

Witness: No sir/ma'am, that is not entirely correct. What I actually said was A, B and C.

You must be quite certain of your testimony to do this. If it is important enough, the attorney may well ask for a "read-back" of your previous testimony and if you were mistaken about your remarks, this may put your credibility in a bad light.

If an attorney asks you to answer a question that would provide only a half-truth or otherwise be open to misinterpretation, it is appropriate to state this. You might reply "The answer to your question would not provide the whole truth" or "If I were to answer your question, it would mislead the jury. Please allow me to explain…"

In general, a witness is not allowed to relate the statements made by another person. Such statements (which you *hear* and then *say* what you heard) are called *hearsay*. There are certain situations, however, in which hearsay evidence is admissible. This includes statements made

spontaneously by someone in an agitated state soon after a dramatic event and heard by another person. Generally speaking, such "excited utterances" occur within minutes to hours of the precipitating event. Statements made by a patient in an emergency department shortly after an injury, for example, might be fit into this description. Another example of admissible hearsay are statements by a patient in the context of a medical history, provided the patient understands your role as a health care provider and is being truthful.

Keep in mind that little is gained in playing the "possible" game with a persistent attorney. Very few physical findings or even constellations of findings have one and only one explanation. Acknowledging that another explanation is "possible" simply affirms this alternative explanation does not defy the laws of physics. For example, just because an injury could have been caused by a child falling so precisely onto a pointed object that it injured only the well-protected hymen and nothing else doesn't mean that you are swayed from your opinion that the child was sexually assaulted.

Virtually all of your answers should be addressed to the jury and/or judge. It is they who are gathering facts and opinions, and it is they who will decide the case. Your appearance as a concerned professional carries a great deal of weight. Your dress, manners and demeanor can serve to enhance (as well as detract from) the testimony you are giving. Avoid, when possible, technical jargon. Refrain from convoluted responses but also be careful not to be condescending when explaining your interpretation of medical findings. In general, the attorneys will assist you in your task by asking for clarification if they sense that the jury is confused or needs further explanation on a given issue since no one on the jury is permitted to ask you any questions.

Only rarely will an attorney try to trip you up or present your testimony in a bad light. But if this happens, the more courteous and controlled you are, the better it will look for you and your testimony and the more foolish the attorney will appear. Do not let yourself get entangled in arguments. If the attorney is being unreasonably aggressive, the judge will likely intervene on your behalf to stop this. Strive to never be the one who is being admonished!

Similarly, never show that you are exasperated, bored, or fatigued. Although these are understandable feelings, expressing them in court will only hurt your credibility as a witness.

You will be dismissed by the judge and no one else. Your cue to leave is NOT the phrase "no further questions." Do not leave the witness stand until the judge has stated "The witness may step down." Walk out of the courtroom calmly and avoid expressions of relief that you are done. As you did during your testimony, maintain your professional appearance to the end, confident in the knowledge that you have done a great service to your patient, your community and our system of justice.

Finally, remember that a post-trial conference can be as educational as the pre-trial one. Ask the attorney and (if you testified for the prosecution) the victim witness advocate with whom you worked what went well and what could have gone better. From your own perspective, offer suggestions about how, as a team, you might improve your approach if you collaborate on similar cases in the future. In this way, every trial, regardless of the outcome, will have educational value for those who seek to ensure that justice will be served.